STATE OF NEW JERSEY

STATE HEALTH BENEFITS PROGRAM

SUMMARY PROGRAM DESCRIPTION

FOR EMPLOYEES AND RETIREES

Department of the Treasury
Division of Pensions and Benefits

January 2002

State of New Jersey
OFFICE OF THE GOVERNOR
PO BOX 001
Trenton, NJ 08625-0001
(609) 292-6000

Christine Todd Whitman
Governor

Dear State Health Benefits Program Member:

Health benefits coverage is rapidly changing. In order to provide you with timely information about the benefits you receive from the State Health Benefits Program (SHBP), we are introducing this new publication - the ***Summary Program Description***.

The *Summary Program Description (SPD)* contains an overview of the SHBP, an up-to-date summary of each health plan offered, and a benefits comparison chart included after the plan summaries. Also included are important phone numbers; other useful contact information; and a section outlining recent benefit changes.

The SPD will help you better understand your health benefits. It gives the new enrollee an introduction to the SHBP, while longstanding members will appreciate the easy reference to covered services and the side-by-side plan comparisons when considering a change of plan.

Once you choose your health plan, you will receive a handbook from that plan with an in-depth description of your benefits and information on how to best use the health plan.

If you have any questions, comments, or suggestions please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, e-mail us at *pensions_nj@tre.state.nj.us* or call us at (609) 292-7524.

Sincerely,

Christine Todd Whitman
Governor

New Jersey Is An Equal Opportunity Employer

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INTRODUCTION

The State Health Benefits Commission (SHBC) is the executive organization responsible for overseeing the State Health Benefits Program (SHBP). The SHBC includes the State Treasurer as the chairperson, the Commissioner of the Department of Banking and Insurance and the Commissioner of the Department of Personnel or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the SHBC. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the SHBP Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP.

State law and the New Jersey Administrative Code govern the SHBP. Although every effort has been made to ensure the accuracy of this *Summary Program Description*, if there are discrepancies between the information presented here and your plan handbook, the law, or regulations, the latter will govern.

OPEN ENROLLMENT

ACTIVE EMPLOYEES

To accommodate the State Health Benefits Program's (SHBP) transition from a fiscal year to a calendar year, the SHBP is holding an Open Enrollment period in the fall of 2000. This Open Enrollment is for all eligible State employees and Local participating employees beginning on September 18, 2000, and ending on October 31, 2000. Coverage changes made during the Open Enrollment period will be effective on December 30, 2000 for all State employees paid through the State's Centralized Payroll Unit, and January 1, 2001, for all other State and Local employees. Completed applications must be returned to your Human Resources representative or payroll officer by October 31, 2000.

Note: There will not be an Open Enrollment period in the spring of 2001.

The annual Open Enrollment periods will occur each fall with coverage effective January of the following year.

The annual Open Enrollment period is your opportunity to make changes to the coverage provided to you and your dependents. During the Open Enrollment period, you may:

- enroll in any of the plans offered by the SHBP, if you have not previously done so;
- change to another SHBP health plan;
- enroll in, or make changes to, a SHBP dental plan (State employees only);
- add dependents you have not previously enrolled; and
- drop dependents (this can also be done at any time during the year).

RETIREES

There is no specific Open Enrollment period for retiree group members. A retiree can switch medical plans once in any 12-month period or when rates change. A retiree may also change plans if the retiree is covered under NJ PLUS or an HMO and moves out of the plan's service area.

For additional retiree transfer and coverage change opportunities, see the Change of Coverage section on page 46.

CHOOSING A HEALTH PLAN

Choosing a health plan is an important decision and one that requires careful consideration. Because there is no single best plan, the SHBP offers a selection of several quality health plans.

To select a health plan that meets your needs, and those of your dependents, review the information available to you in this booklet, any additional information available from the health plans, and consider the following factors:

COVERAGE

Each plan offers a variety of services. For example: some plans cover preventive and wellness services while others do not. The SHBP creates a plan comparison chart each year that provides important information to our employees and retirees. The benefit section of this chart is reproduced on pages 30 - 35. To obtain a copy of the complete chart, see your employer or call the Division's Benefit Information Library at (609) 777-1931 and enter information selection number 130. After the recorded information, you can request that a copy of the chart be mailed to you. The comparison information is also available over the Internet at: *www.state.nj.us/treasury/pensions/shbp.htm*

Additional plan information is also available by calling the plans you are interested in. Telephone numbers, addresses, and Internet addresses are found in each plan description beginning on page 11.

CHOICE OF PROVIDER

The **Traditional Plan** allows you to use any licensed medical provider or hospital facility. Should you need specialist care, you may also choose to use any licensed specialist. Benefits are payable subject to deductibles and coinsurance.

The **Health Maintenance Organizations (HMOs)** offer a list of participating providers from which you may select a Primary Care Physician (PCP). That physician coordinates all your care. Other than Physicians Health Services HMO which allows open access to participating specialists, referrals must be obtained from your PCP in order for you to visit a specialist. Some HMOs allow gynecologists and pediatricians as primary care physicians. The annual GYN visit does not require a referral. Further information can be found in each plan's summary or you may call the plan directly.

NJ PLUS is a point-of-service plan, meaning you decide which provider to use when you need a service. It is basically a blend of the Traditional Plan and an HMO. NJ PLUS has in-network benefits which apply when you select and use a primary care physician from the list of participating providers. As with an HMO, all care is coordinated though your PCP. Referrals must be obtained from your PCP in order for you to visit a specialist. NJ PLUS also offers out-of-network benefits that allow you to use any licensed medical provider or hospital facility. In-network benefits are provided subject to the payment of the applicable co-payment. Out-of-network benefits are payable subject to a deductible and coinsurance.

How to Access Information That Can Help You Choose a Provider

To help you find a physician, or to determine that a physician you wish to use is in a certain plan, call the plan directly to request a provider directory or check the plan's Website for a listing of the participating physicians. In addition, the SHBP offers the Unified Provider Directory (UPD). Updated monthly, the UPD is available over the Internet and contains information about health care providers and facilities that deliver their services through one or more of the SHBP's managed-care plans. The information is in an easy to use format so you will no longer have to search through numerous provider directories to determine if a provider participates in a plan in which you are interested. The UPD can be reached through the SHBP Internet homepage at: *www.state.nj.us/treasury/pensions/shbp.htm*

CONVENIENCE

Some plans may have certain providers who are affiliated with hospitals that are more convenient to your home or workplace. It is important to consider the hospital affiliation of your selected provider as well as the location of the provider's office. This information can be obtained from the health plan, the UPD (see above), or by contacting the provider directly.

COST

While "price should be no object" when the health of you and your family are concerned, you need to be aware of the potential costs for the benefits you receive.

Depending upon the labor organization (union) representing you, you may be required to pay premiums or share in the cost of your health plan. Check with your Human Resources representative or the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524 to determine if you are required to pay any portion of the cost of your health care.

The **Traditional Plan** and **NJ PLUS out-of-network** benefits require that an annual deductible be met, and services are reimbursed subject to coinsurance based on reasonable and customary allowance for the service. Therefore, in a plan like the Traditional Plan or when utilizing NJ PLUS out-of-network benefits, out-of-pocket expenses will include any difference between the allowable charge and the billed amount.

HMOs and **NJ PLUS in-network** benefits require co-payments for routine services such as office visits, use of emergency rooms, etc. When using an HMO or NJ PLUS in-network there is no deductible or coinsurance and reasonable and customary charges do not apply.

EMPLOYEE ASSISTANCE PROGRAMS

Employee Assistance Programs (EAP) are staffed by professional counselors who can help employees and their eligible dependents handle problems such as stress, alcoholism, drug abuse, mental health conditions, and family difficulties. An EAP will provide education, information, counseling, and individual referrals to assist with a wide range of personal or social problems. The EAP will also assist you in obtaining a referral to the proper health care provider, and help in day-to-day communications with your health plan.

An employee's contact with this service is private, privileged, and strictly confidential. No information will be shared with anyone at anytime without your written consent.

The following EAP services are available to State Employees:

State Employee Advisory Service (EAS) . . . . . Active State Employees	(609) 292-8543
Rutgers University Personnel Counseling Service (EAP)	(732) 932-7539
New Jersey State Police EAP	(856) 234-5652 (908) 231-1077 (609) 633-3718 1-800-FOR-NJSP
University of Medicine and Dentistry of New Jersey EAP	(973) 972-5429

Employees of local employers may have an EAP available to them. To find out about such services you should check with your employer's Human Resource Office.

TAX$AVE FOR STATE EMPLOYEES

Tax$ave is a benefit program available to State employees under Section 125 of the federal Internal Revenue Service Code. This voluntary program allows eligible employees to set aside before tax dollars to pay for certain medical, dental, and dependent care expenses, thereby avoiding federal taxes and saving money. Tax$ave consists of three components:

— The **Premium Option Plan** (POP) allows employees to pay any State Health Benefits Program medical and/or dental premiums they may have with before tax dollars.

— The **Unreimbursed Medical Spending Account Plan** (UMSA) allows employees to set aside money to pay for qualified medical and dental expenses not paid by any group benefits plan under which they or their dependents are covered.

— The **Dependent Care Spending Account Plan** (DCSA) allows an employee to set aside funds to pay for anticipated expenses related to dependent care required to permit the employee and spouse to work.

You may join Tax$ave or make changes to your Tax$ave plan during the Open Enrollment period (September 18 through October 31, 2000). Call Horizon Healthcare Insurance Agency at 1-800-224-4426 for more information.

PRESCRIPTION DRUG BENEFITS

EMPLOYEE PRESCRIPTION DRUG PLAN

The Employee Prescription Drug Plan is offered to active State employees and their eligible dependents as a separate drug plan. Local employers may also elect to provide the SHBP Employee Prescription Drug Plan to their employees as a separate prescription drug benefit.

The Prescription Drug Plan is currently administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) through Merck-Medco, L.L.C., and its affiliate, PAID Prescriptions, L.L.C.

Plan Benefits

For each 30-day supply obtained at a retail pharmacy, participants pay a $1.00 co-payment for **generic** drugs and a $5.00 co-payment for **brand name drugs**. You may purchase up to a 90-day supply of medication at a pharmacy when prescribed by your provider, by paying the applicable co-payments (60-day supply — two co-payments, 90-day supply — three co-payments).

A mail order program is also available. When mail order is used, up to a 90-day supply of medication has a $1.00 co-payment for **generic** drugs and a $5.00 co-payment for **brand name** drugs.

The State Health Benefits Commission has required that all participating employees and retirees have access to prescription drug coverage. If you are employed by a county, municipality, board of education, or other local public employer who does not provide a separate prescription drug plan, medical plans offered through the SHBP will include prescription drug benefits.

If you are eligible for prescription drug coverage through a separate drug plan provided by your employer, your SHBP medical plan will not include prescription drug coverage. Also, any prescription drug co-payments from other group plans are not reimbursable through the Traditional Plan, NJ PLUS, or any SHBP HMO.

Traditional Plan and NJ PLUS

Active employees whose employer does not offer a separate prescription drug plan have prescription drug coverage through the Traditional Plan and NJ PLUS. This provides access to a discounted prescription drug reimbursement program through their plan's benefits. By presenting a discount prescription card to the pharmacist, members are charged a reduced fee and the claim is electronically submitted to the plan for consideration. See the plan descriptions for specific details.

Participating SHBP HMOs

The SHBP HMOs provide a prescription drug card benefit for those employees whose employer does not offer a separate prescription drug plan. Co-payments when using an HMO drug card vary by plan but cannot exceed $10 per prescription if prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. See the plan descriptions for specific details. A mail order program may also be available depending on the HMO you select.

RETIREE PRESCRIPTION DRUG COVERAGE

Effective January 1, 2000, retirees enrolled in the **Traditional Plan** or **NJ PLUS** have access to a separate prescription drug card plan that includes a mail order service. The plan features a three-tiered design. More information about the program is available in the Traditional and NJ PLUS plan descriptions in this booklet.

The SHBP **HMOs** provide retirees with prescription benefits through the use of a prescription drug card. Co-payments when using an HMO drug card vary by plan but cannot exceed $10 per prescription if prescribed by your Primary Care Physician (PCP) or a provider to whom your PCP has referred you. See the plan descriptions for specific details. A mail order program may also be available depending on the HMO you select.

RECENT BENEFIT CHANGES

GENERAL CHANGES

Cancer Clinical Trials

On December 16, 1999, Governor Whitman announced an agreement with the major health insurers in New Jersey to cover routine medical services offered through cancer clinical trials. The coverage includes benefits provided for the routine costs associated with the administration of drugs, such as hospitalization, outpatient visits, physician fees, and laboratory tests.

The State Health Benefits Commission on April 26, 2000, voted to approve the inclusion of cancer clinical trial coverage for all self-funded plans in the SHBP. Currently all State Health Benefits Program medical plans provide benefits for cancer clinical trials.

Services Involving Treatment of Biologically-Based Mental Illnesses

Effective July 1, 2000, services rendered for the treatment of a biologically-based mental illness are treated like any other illness and are not subject to the annual and lifetime mental health maximums. Biologically-based mental illness includes, but is not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, and pervasive developmental disorder or autism.

Women's Health and Cancer Rights Act

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans, which cover mastectomies, must cover breast reconstruction; surgery to produce a symmetrical appearance; prostheses; and treatment of any physical complications.

Plans for Medicare Recipients

As of January 1, 1999, all Medicare+Choice HMOs were eliminated from the SHBP. If you are a SHBP eligible retiree and are also covered by Medicare, you may enroll in any of the health plans offered by the SHBP. Benefits under all plans supplement benefits provided by Medicare so that medical coverage is identical to that of active employees.

Your SHBP health plan will pay benefits after Medicare has made their payment to your medical provider. You pay the appropriate co-payment, deductible, or coinsurance amounts when services are rendered. Generally your provider will submit your expenses to Medicare for their handling and then to your SHBP health plan for their supplemental payment. However some services, especially hospital services and services provided out-of-state, may not be automatically sent to your SHBP health plan. You may have to forward your Medicare *Explanation of Benefits* to your health plan for payment to be made to your provider. Both Medicare and your health plan should send all benefits directly to the provider of the service; however, if you receive a benefit check in error, you should either endorse the check over to your provider or cash the check and pay your provider directly.

TRADITIONAL PLAN AND NJ PLUS CHANGES

Prescription Drug Limitations

Coverage is limited on prescriptions for Viagra to a four pill per 30-day maximum. Other prescription limitations include — Muse (6 units/pellet per 30 days); Edex (4 units/kit or 6 units/vial per 30 days); Caverject (6 units/kit or 6 units/vial per 30 days).

Biofeedback for Eligible Medical Diagnoses

Expenses for biofeedback for medical diagnoses will be charged to major medical coverage. Expenses for all mental health diagnoses will be reimbursed in accordance with the plan's mental health benefit. Expenses for biofeedback for non-biologically-based mental illness (see page 6) will be applied to the mental health maximum.

Retiree Prescription Drug Card Program

Effective January 1, 2000, retirees enrolled in the Traditional Plan or NJ PLUS have access to a separate prescription drug card plan that includes a mail order service. The plan features a three-tiered co-payment design. More information about the program is available in the Traditional and NJ PLUS plan descriptions in this booklet.

Alcohol and Substance Abuse

NJ PLUS: There are no co-payments required for outpatient alcohol and substance abuse treatment. Alcohol and substance abuse expenses are not to be applied to the annual or lifetime mental health benefit maximum.

HMO CHANGES

General Operating Procedures

SHBP Standardized Benefits, General Operating Procedures, and Conditions of Participation were instituted for all HMOs. (See section entitled HMO Plan Standards on page 36.)

STATE HEALTH BENEFITS PROGRAM CONTACT INFORMATION

Health plan telephone numbers and mailing addresses are located in the individual plan descriptions beginning on page 11.

ADDRESSES

Our Mailing Address is . . . . . The State Health Benefits Program
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

Our Internet Address is . . . . . *www.state.nj.us/treasury/pensions/shbp.htm*

Our E-mail Address is . . . . . *pensions_nj@tre.state.nj.us*

TELEPHONE NUMBERS

Division of Pensions and Benefits:	
Benefit Information Library/Fax on Demand	(609) 777-1931
Office of Client Services	(609) 292-7524
TDD Phone (Hearing Impaired)	(609) 292-7718
State Employee Advisory Service (EAS)	(609) 292-8543
Rutgers University Personnel Counseling Service (EAP)	(732) 932-7539
New Jersey State Police	
Employee Advisory Program (EAP)	(856) 234-5652
	(908) 231-1077
	(609) 633-3718
	1-800-FOR-NJSP
University of Medicine an Dentistry of New Jersey (EAP)	(973) 972-5429
New Jersey Department of Banking and Insurance	
Individual Health Coverage Program Board	1-800-838-0935
Consumer Assistance for Health Insurance	(609) 292-5316
New Jersey Department of Human Services	
Pharmaceutical Assistance to the Aged and Disabled (PAAD)	1-800-792-9745
Independent Health Care Appeals Program	(609) 633-0660
New Jersey Department of Health and Senior Services	
Division on Senior Affairs	1-800-792-8820
Insurance Counseling	1-800-792-8820
Health Care Financing Administration - Medicare	1-800-638-6833
New Jersey Medicare - Part A	(423) 755-5955
New Jersey Medicare - Part B	1-800-462-9306

SHBP RELATED PUBLICATIONS

The publications and fact sheets available from the Division of Pensions and Benefits provide information on a variety of subjects.

Employees and retirees can obtain copies of these publications by contacting their employers or by calling the Division of Pensions and Benefits. Our Benefit Information Library (BIL) is available 24 hours-a-day, seven days-a-week. If the items you require have a BIL number, dial (609) 777-1931, from a touch-tone phone, and enter the three-digit BIL selection number when instructed. After the recorded information leave your name, mailing address with ZIP Code, and Social Security number to have the publication or fact sheet mailed to you.

If the items you require have a Fax on Demand (FOD) number, you can have the publication or fact sheet automatically faxed to your fax machine. To use our Fax on Demand service, dial (609) 777-1931. Follow the instructions to access Fax on Demand and, when requested, enter the four-digit FOD selection number along with your fax number (area code and telephone).

General Publications

State Health Benefits Program Comparison Summary - Plan comparison chart. (BIL #130)

Benefit Information Library Catalog - The full catalog of informational items available through the Division of Pensions and Benefits' - Benefit Information Library and Fax on Demand service. (FOD #8000)

SHBP Fact Sheets

Fact Sheet #11, *Enrolling in the State Health Benefits Program When you Retire.* (BIL #208) (FOD #8208)

Fact Sheet #25, *Employer Responsibilities under COBRA.* (BIL #345) (FOD #8345)

Fact Sheet #26, *Health Benefits Options upon Termination of Employment.* (BIL #258) (FOD #8258)

Fact Sheet #30, *The Continuation of New Jersey State Health Benefits Program Coverage Under COBRA.* (BIL #254) (FOD #8254)

Fact sheets and other publications are also available for viewing or downloading over the Internet at: *www.state.nj.us/treasury/pensions*

1999 New Jersey HMO Performance Report: Compare Your Choices.

You can compare quality ratings of various HMO's with the New Jersey Department of Health and Senior Services' 1999 *New Jersey HMO Performance Report: Compare Your Choices.* A summary of selected report data, as it relates to HMOs in the SHBP, is provided in the chart below.

From the health plans that seem to best fit your needs, check the issues that are most important to you and your family. For example, if you have a young child, you might be most interested in the performance measures in the Care for Kids section of the report. Be careful, however, not to make decisions based on small differences that are not meaningful. Look at all factors that contribute to a health plan's performance, not just results for a single measure.

To obtain a complete copy of the 1999 *New Jersey HMO Performance Report: Compare Your Choices,* contact the New Jersey Department of Health and Senior Services, Office of Managed-Care, PO Box 360, Trenton, NJ 08625-0360, or call 1-888-393-1062. The report is also available over the Internet at: *www.state.nj.us/health*

To get additional information from the health plans you are most interested in joining, see the following Plan Description Pages.

COMPARISON OF SHBP HEALTH MAINTENANCE ORGANIZATIONS BASED ON DEPARTMENT OF HEALTH AND SENIOR SERVICES — 1999 NJ HMO PERFORMANCE REPORT

	CATEGORIES					
PLAN NAME	QUALITY AND EASE OF ACCESS TO SERVICES	SATISFACTION WITH DOCTORS AND MEDICAL CARE	QUALITY OF PREVENTIVE CARE	QUALITY OF CARE FOR KIDS	QUALITY OF TREATMENT FOR CHRONIC ILLNESS	QUALITY OF SERVICES FOR FREQUENT USERS OF THE PLAN
Aetna US Healthcare	11	8	9	9	11	10
AmeriHealth	12	11	6	12	10	12
CIGNA HealthCare	8	8	4	8	6	8
Horizon HMO[1]	10	8	7	8	11	8
Oxford Health Plan	8	8	10	10	8	8
Physicians Health Services	8	8	8	7	4	8

Each category is based on four measures. The score summarizes how well a plan performed on the four measures in each category. The higher the score, the better the rating. In each measure 3 points were given for an above average rating, 2 points for an average rating, and 1 point for a below average rating. The highest score for each category is 12, the lowest score is 4.

[1] The **NJ PLUS in-network plan** (in New Jersey) shares the same panels of providers as Horizon HMO.

University Health Plans was not required to report and is not shown.

For rating details see the *1999 New Jersey HMO Performance Report: Compare Your Choices*.

PLAN DESCRIPTIONS

The information on the following plan description pages is supplied by each individual health plan and intended to provide a brief overview of the plan and the benefits it offers. If there are discrepancies between the information presented in these pages and the law, regulations, or contracts, the latter will govern. If you have questions or concerns about the information presented please write to the State Health Benefits Program, Division of Pensions and Benefits, PO Box 299, Trenton, NJ 08625-0299.

Aetna U.S. Healthcare is one of the largest providers of managed health care services in America. With nearly 14 million health members more than 40 percent of the nation's Fortune 1000 companies choose Aetna U.S. Healthcare for their health plans.

Medical care for employees can be obtained through private practice physicians located throughout all of New Jersey, Connecticut, Washington DC, Texas, Georgia, California, and parts of Pennsylvania, New York, Maryland, Virginia, Illinois, and Delaware.

Retirees may not be able to enroll in all locations.

AUSHC HMO Plan offers comprehensive coverage with the added benefit of low out-of-pocket costs. Each Aetna U.S. Healthcare member selects a participating primary care physician who is an internist, family doctor, pediatrician, or a general practitioner. Additionally, each female member can select a participating gynecologist for routine gynecological care when applicable. All routine and preventive care received in the participating primary care physician's office is fully covered with a $5 co-payment. This includes physical examinations, eye exams, and well-baby visits. Emergency care is covered anytime anywhere in the world. In any of these situations, there are no claim forms to fill out and no deductibles to pay.

Retirees enrolled in Aetna U.S. Healthcare and their dependents who are eligible for Medicare will have the same benefits, the same co-payments, and with a few exceptions, the same providers as those who are not eligible for Medicare but Medicare will be the primary payer. Aetna U.S. Healthcare provides Medicare covered enrollees with a different identification card which indicates that the enrollee and/or dependent is eligible for the Medicare Elect Choice Plan. You should present your Medicare identification card and your Elect Choice card when receiving medical services.

Vision Care — You are eligible to receive substantial discounts on eyeglasses, contact lenses, and nonprescription items such as sunglasses and contact lens solutions through the Vision One Program at more than 2,500 locations across the country. For more details about Vision One and to receive a listing of vision stores in your area, call 1-800-793-8616 weekdays 9 a.m. - 9 p.m., Saturdays 9 a.m. - 5 p.m. EST.

Prescription Drug Coverage — Prescription drugs including insulin are covered. Each prescription is limited to a maximum 30-day retail supply, with up to five refills when authorized. There is a $10 co-payment per prescription or refill. The mail order co-payment is $10 with a maximum 90-day supply.

Women's Health for Life Programs — Aetna U.S. Healthcare is committed to providing a variety of services and education emphasizing issues and concerns shared by women through all stages of their life. We help you maintain good health through ambitious outreach programs that remind you to screen regularly for breast, colorectal and

cervical cancer.

Open Access Gynecology Program — Our female members may also visit a gynecologist without a referral for routine well-woman exams, including a Pap smear, gynecological-related problems, follow-up care, and obstetrical care. Gynecologists may also refer you directly to other specialists for other appropriate gynecological services.

Disease Management — Aetna U.S. Healthcare's expertise in data analysis has led to the creation of special programs for chronically ill members who cope with such conditions as heart disease, asthma or diabetes. Our disease management programs give members and physicians information that helps reduce hospitalizations and improve health and the quality of life.

Cancer Screening Programs — The probability of successfully treating breast, cervical, prostate, and colorectal cancers is enhanced through early diagnosis and prompt treatment. Aetna U.S. Healthcare Check® Program now recommends annual mammography screening for female members beginning at age 40.

Members Education Resources — You'll get a FREE subscription to our exclusive magazine, Apple Seeds, which contains important health information, safety tips, recipes and more. You'll also learn how to get the most out of your Aetna U.S. Healthcare benefits.

Mental Health and Substance Abuse Care — Your total well being is important to us. That's why mental health and substance abuse treatments are covered.

Electronic Referrals — We've developed a new system that electronically transmits referrals, referral inquires, and member eligibility to participating specialists and back to Aetna U.S. Healthcare. This system eliminates the need to pick up a referral once your primary care physician has authorized specialty care. The electronic referral system is in the process of being implemented, with more offices being rolled out every month.

1-800-PIC-A-DOC/DocFind® — It's easy to choose a primary care physician from our extensive network of independent providers in private practice. Through a toll-free hotline 1-800-PIC-A-DOC - you may get a "report card" on participating primary care doctors… including information on credentials, office hours and member satisfaction survey results.

We've also made it easy for you to choose a physician from our extensive network via the Internet. With DocFind, your can conduct an online search for participating doctors, hospital and other providers. To use DocFind, simply go to the following Internet address: *www.aetnaushc.com* You can then select a provider based on geographic location, medical specialty, and/or hospital affiliation.

For additional information please call 1-800-309-2386. Customer service representatives are available to answer your questions 8 a.m. to 6 p.m. Monday to Friday.

AmeriHealth HMO

AmeriHealth HMO, Inc. and its affiliate companies serve more than 4 million members. By drawing on more than 60 years of experience, AmeriHealth HMO and its affiliates have the knowledge and resources to deliver quality heath care coverage. We strive to continually enhance our programs, technology, and customer service in an effort to find new ways to meet member needs.

Network

AmeriHealth HMO offers one of the largest provider networks with nearly 8,000 primary care physicians, more than 21,000 specialists, and 185 hospitals. Our provider network spans the entire States of New Jersey and Delaware, and Southeastern Pennsylvania. Our network includes providers from many medical fields. In addition, HMO members have nationwide access to care through the largest network of HMOs in the country. Across the country and around the world, our members have peace of mind when they carry our card because of the comprehensive coverage we provide.

Quality

AmeriHealth HMO is committed to quality care for our members, so we carefully review providers before inviting them into our network. We believe that the care and coverage that we offer is high quality. Both state and national organizations have recognized AmeriHealth HMO for excellence in our programs and services. For the third consecutive year, AmeriHealth HMO earned top scores in the State of New Jersey *HMO Performance Report: Compare Your Choices*. AmeriHealth HMO scored higher than our competitors earning above State average scores in 17 of the 24 categories. In addition, AmeriHealth has been accredited by the National Committee for Quality Assurance (NCQA).

Core Benefits and Special Services

AmeriHealth HMO covers doctor visits, specialty care, hospital services, and out-of-area coverage. Most visits are covered 100 percent with just a $5 co-payment. Our benefits include full preventive care services including periodic health assessments, immunizations, routine gynecological care, and well baby/well child care. AmeriHealth HMO covers most prescription drugs with a co-payment of $6 for generic drugs and $10 for brand name drugs. More than 53,000 pharmacies nationwide participate in the pharmacy network, including independent pharmacies and local and national chains. And members do not have to pre-select one pharmacy. We also offer a preventive pediatric dental program for children under age 12.

AmeriHealth Healthy Lifestyles℠ Wellness Program

AmeriHealth HMO offers the AmeriHealth Healthy Lifestyles℠ wellness programs for each

stage of your family's life. There is no other health insurer in the area that offers all the comprehensive, value added wellness programs that AmeriHealth offers as part of our managed care plans. The discounts, reimbursements and special incentives available through our AmeriHealth Healthy Lifestyles programs can provide extra value to your health care coverage. We have recently refined these programs to make them more accessible and easy to use. The AmeriHealth Healthy Lifestyles programs consist of four portfolios including Health Management, Women's Health, Alternative Health and Family Health. AmeriHealth HMO welcomes inquiries from prospective members Monday through Friday, 8:30 a.m. to 5:00 p.m.

Connections Health Management Programs

These programs are designed to help members with chronic conditions improve their health and the overall quality of their lives. Enrollment in Connections is easy and voluntary. If you have a chronic condition, talk to your Primary Care Physician or family doctor about how Connections can help you. Available programs include asthma, diabetes, congestive heart failure, cardiac, and total joint replacement.

Baby FootSteps

Our maternity program helps identify possible risk factors during pregnancy. It also offers educational materials and up to $40 back for the cost of any childbirth class.

Pediatric Immunization

To help parents ensure their children are fully vaccinated by age two, we send special mailings to parents with a recommended schedule of immunizations. Answers to commonly asked questions and concerns are also included.

For Additional Information

Mail

AmeriHealth HMO, Inc.
8000 Midlantic Drive
Suite 333
Mt. Laurel, NJ 08054
856-778-6500

AmeriHealth HMO, Inc.
485 Route 1 South
3rd Floor, Building C
Iselin, NJ 08830
732-726-6700

Internet

www.amerihealth.com

This overview is intended to highlight the benefits available. For complete descriptions, including all benefits and exclusions, refer to the AmeriHealth HMO benefit booklet.

The National Committee for Quality Assurance has awarded CIGNA HealthCare of New Jersey and CIGNA HealthCare of New York a three-year Full Accreditation.

HERE ARE THE MAIN FEATURES OF YOUR PLAN:

Carefully Chosen Physicians

Before a physician is admitted to our network, your local CIGNA HealthCare health plan thoroughly reviews his or her education, practice history and other credentials. We have similar review procedures for hospitals and other providers.

Carefully Designed Networks

Our quality standards also specify easy access to our participating doctors and hospitals. Our service area includes participating providers in New Jersey, New York, Philadelphia, Delaware and Connecticut representing over 10,000 primary care physicians and over 23,500 specialists.

Emergency Coverage

No matter where you travel in the U.S. or worldwide, you are covered for emergency care.

Direct Access for Obstetrical and Gynecological Services

Women are allowed direct access to a qualified participating provider for obstetrical and gynecological services covered by this plan. This means that you are not required to obtain authorization from your Primary Care Physician for visits to the participating provider of your choice for pregnancy and preventative gynecological conditions.

CIGNA HealthCare Healthy Babies®

A prenatal care program that includes education for mothers-to-be as well as screening and special care for high-risk pregnancies.

The CIGNA HealthCare Well Aware Program for Better Health℠

The Well Aware program provides valuable self-care tools and educational materials that support a carefully monitored physician care program for chronic conditions like low back pain, asthma, and diabetes.

The CIGNA LIFESOURCE Organ Transplant Network®

A program that provides transplant recipients with access to the nation's leading transplant centers.

The CIGNA HealthCare 24-Hour Health Information Line℠

A specially-trained team of registered nurses is available 24 hours a day, 365 days a year. They're available to provide valuable health information and self-care advice. In situations regarding urgent or emergency care, they also help with authorizations required by your plan. You can also use our Health Information Library to hear pre-recorded programs on hundreds of health and medical topics.

Prescription Drugs

Prescriptions and refills covered up to 30-day supply when purchased at a participating pharmacy. Coverage is provided for generic and brand name drugs as prescribed by your doctor. Coverage is provided for diabetic drugs and supplies and includes insulin,

insulin syringes and needles, glucose test strips and lancets. Prenatal vitamins are also covered. Coverage is provided for contraceptive devices and oral fertility drugs.

Retail Pharmacy

Per prescription 30-day supply

Generic $5

Brand $10

(Prescription coverage through CIGNA may not be applicable to all employees.)

Mail Order Plan

Per prescription 90-day supply

Generic $10

Brand $10

Vision Care

To obtain vision care services, please call Vision Service Plan toll-free at 1-800-622-7444
Exam: $5 per visit; once every 12 months.
Hardware: not covered

Take Charge of Your Health

If you have asthma, low back pain, or diabetes we offer the CIGNA HealthCare Well Aware Program for Better Health that may interest you. The innovative Well Aware programs are designed to help you better manage your condition and improve your quality of life.

If you would like more information about the Well Aware program, call Member Services at the number on your CIGNA HealthCare ID card.

Visit us Online

Isn't it time you stopped by for a visit? We think you'll be pleased by the services that are available to you on our Web site. By visiting us at *www.cigna.com*, you can:

— Change your Primary Care Physician.

— Find doctors, hospitals, dentists and pharmacies in your area that are in the CIGNA HealthCare network and download a personalized provider directory.

— Find out if a doctor is accepting new patients.

— If you have pharmacy benefits through CIGNA HealthCare, you can order your refills through our mail-order pharmacy.

We want to make it as easy as possible for you to use your health plan. So visit us soon and take advantage of these convenient online services.

QUESTIONS?

If you'd like more information about CIGNA HealthCare or how we serve your community, just call Member Services at 1-800-832-3211 between 8:00am and 6:00pm.

To learn more about CIGNA, or to e-mail us anytime you have a question, visit us at **www.cigna.com/healthcare.**

CIGNA HEALTHCARE
200 Regency Executive Park
Charlotte, North Carolina 28217

Horizon HMO, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey, was one of the first HMOs available under the State Health Benefits Program (SHBP). Members may select from a network of over 13,000 providers available in all counties in New Jersey and Bucks County, Pennsylvania. Approximately, 4,000 of these providers are Primary Care Physicians (PCP). All providers participating in the Horizon HMO network are carefully selected and screened and must meet rigorous professional standards. Periodically, we review the credentials of participating providers and profile their performance to ensure that members receive the best medical care available. In addition, Horizon HMO has received full accreditation from the National Committee for Quality Assurance (NCQA).

You and Your Primary Care Physician

Your PCP will provide you with routine care, including annual physical examinations, well-child care and immunizations. There is a $5 co-payment each time you visit your PCP. You may change your PCP simply by calling Member Services. If you and your PCP determine you need to see a specialist, a referral will be issued to a participating provider. There is a $5 co-payment per specialist office visit. Your PCP will also coordinate your hospital care through our broad network of 65 New Jersey hospitals in 76 locations and you will receive 100 percent coverage.

Obstetrician/Gynecologist Coverage

Female members have direct access to participating Obstetricians/Gynecologists (OB/Gyns) without PCP referral. This includes an annual well-woman exam and other OB/Gyn related services. There is a $5 co-payment per OB/Gyn visit. This co-payment is waived for prenatal and postnatal maternity care visits after the initial visit.

Vision Coverage

Members have direct access to a participating optometrist or ophthalmologist for an annual vision examination. There is a $5 co-payment for an annual vision examination. Additional visits require written referral from your PCP and also require a $5 co-payment per visit.

Prescription Drug Coverage

Prescription drug coverage is provided to employees whose employer does not offer a separate, prescription drug plan. Prescription drug coverage is also provided to retirees. A $5 generic drug co-payment and a $10 brand name co-payment applies at a retail pharmacy for up to a 30-day supply. Mail order is also available with a $5 generic co-payment and a $5 brand name co-payment for up to a 90-day supply.

Emergency Care

If you experience a medical emergency, please go to the nearest emergency facility immediately. You must contact us and your PCP within 48 hours. A $25 co-payment applies if you are treated and released but is waived if you are admitted to the hospital. Please note all Horizon HMO PCPs have 24-hour back up coverage in the event he/she is unavailable.

Away-From-Home Coverage

Horizon HMO covers you and your eligible family members when traveling or temporarily away from home through HMO Blue USA, a national Blue Cross Blue Shield HMO network serving over 250 major cities and all 50 states, as well as Puerto Rico. Or, if you are away from home for an extended period of time, enrollment may be granted through our Guest Membership Program in a Blue Cross Blue Shield sponsored HMO in another state.

Horizon HMO Specialty Programs/Features

Precious Additions® - a prenatal education and information program that helps expectant mothers enjoy a healthy pregnancy. After the birth, the program offers home care services and encourages child immunizations.

SmartEyes℠ - a discount program for eyeglasses and accessories through more than 6,500 Cole Vision/Pearle Vision Centers nationwide. Cole Vision outlets can be found in Sears Optical Centers, JC Penney Optical Centers, and Montgomery Ward Vision Centers. Call 1-800-424-1155 for a location near you.

Centers of Excellence - a network of regional hospitals for bone marrow, heart, lung, liver and kidney transplants, should they be necessary.

Focus Newsletter - a free subscription to our quarterly newsletter, FOCUS, which gives you health tips and benefit updates.

Health and Fitness Discount Program - discounts for weight loss, smoking cessation and stress management programs, health club memberships, and other healthy lifestyle programs.

For Additional Information

If you have questions, please call Horizon HMO Member Services at 1-800-355-BLUE (2583) during our service hours of Monday through Friday, 8:00 a.m. to 8:00 p.m. You may also access our interactive Web-Site at **www.horizon-bcbsnj.com** or write to us at:

Horizon Blue Cross Blue Shield of New Jersey
Horizon HMO
P.O. Box 820
Newark, New Jersey 07101-0820

NJ PLUS is a point-of-service (POS) plan administered by Horizon Blue Cross Blue Shield of New Jersey. NJ PLUS provides you the best of both worlds: in-network care similar to an HMO plan and out-of-network care similar to a traditional plan. Members that wish to use the in-network level of coverage may select from over 45,000 participating providers and more than 300 participating hospitals in a service area covering all of New Jersey and Delaware and parts of Pennsylvania and New York. Members that wish to use the out-of-network level of coverage, have the freedom to access any eligible provider or hospital of their choice in an unrestricted service area. All providers participating in the NJ PLUS network are carefully selected and screened and must meet rigorous professional standards. Periodically, we review the credentials of participating providers and profile their performance to ensure that members receive the best medical care available.

In-Network Coverage

Upon enrolling, you are encouraged to select a Primary Care Physician (PCP) for yourself and eligible family members. PCPs can be located in any part of the service area and can be different for each family member. You may change your PCP simply by calling Member Services. Your PCP will provide routine care, including annual physical examinations, well-child care and immunizations with a $5 co-payment per visit. If you need to see a specialist, your PCP will issue a referral to a participating provider with a $5 co-payment per visit. Your PCP will also coordinate your hospital care though the NJ PLUS hospital network and you will receive 100 percent coverage.

Female members have direct access to participating Obstetricians/Gynecologists (OB/Gyns) without PCP referral. This includes an annual well-woman exam and other OB/Gyn related services. A $5 co-payment applies per visit, but is waived for prenatal and postnatal maternity care visits after the initial visit.

All members have direct access to a participating optometrist or ophthalmologist for an annual vision examination with a $5 co-payment. Additional visits require a PCP referral and a $5 co-payment.

Out-of-Network Coverage

When you use out-of-network benefits you incur an annual deductible and coinsurance requirement of 30 percent of reasonable and customary charges. In addition, each out-of-network hospital admission requires a $200 deductible. Preventive care or well care, except immunizations for children under 12 months, is not covered at the out-of-network level.

Emergency Care

If you experience a medical emergency, please go to the nearest emergency facility immediately. You must contact NJ PLUS and your PCP within 48 hours. A $25 co-payment applies if you are treated and released but is waived if you are admitted to the hospital. If you do not contact us, coverage will be at 70 percent after an annual deductible. Please note all NJ PLUS PCPs have 24-hour back up coverage in the event he/she is unavailable.

Prescription Drug Coverage

Active Local Employees -

Without a separate Prescription Drug Program

If you are an active employee and your employer does not offer a separate prescription drug plan, NJ PLUS provides a dis-

counted prescription drug reimbursement program, when you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. NJ PLUS will reimburse 90 percent of the cost of prescriptions that are written by your network provider and 70 percent of the cost of prescriptions, less deductibles, written by your out-of-network provider.

Prescription Drug Coverage

Retirees

Retail Pharmacy - up to 90-day supply co-payment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	$5	$10	$20
31-60 days	$10	$20	$40
61-90 days	$15	$30	$60

Mail Order - 90-day supply co-payment amounts

Generic	$5 co-payment
Preferred Brand	$15 co-payment
All Other Brands	$25 co-payment

There is a $300 annual maximum in prescription drug co-payments per person. Once a person has paid $300 in co-payments in a calendar year, that person is no longer required to pay any drug co-payments for the remainder of that year. Prescription drug co-payments are not eligible for reimbursement and do not apply to the NJ PLUS (out-of-network) deductible.

NJ PLUS Specialty Programs/Features

Precious Additions® - an education and information program for new and expectant mothers.

SmartEyes℠ - a discount program for eyeglasses and accessories through more than 6,500 Cole Vision/Pearle Vision Centers nationwide. Cole Vision outlets can be found in Sears Optical Centers, JC Penney Optical Centers, and Montgomery Ward Vision Centers. Call 1-800-424-1155 for a location near you.

Centers of Excellence - a network of regional hospitals for bone marrow, heart, lung, liver, and kidney transplants, should they be necessary.

Focus Newsletter - a free subscription to our quarterly newsletter for health tips and benefit updates.

Health and Fitness Discount Program - discounts for weight loss, smoking cessation, and stress management programs, health club memberships, and other healthy lifestyle programs.

For Additional Information

If you have questions, please call NJ PLUS Member Services at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 8:00 p.m. You may also access our interactive Web-Site at **www.horizon-bcbsnj.com** or write to us at:

Horizon Blue Cross Blue Shield of New Jersey
NJ PLUS
P.O. Box 820
Newark, New Jersey 07101-0820

ACCESS TO QUALITY CARE

- **Ensuring network quality** - Oxford knows a big part of healthcare is the peace of mind that comes with choosing a provider that is not only knowledgeable in his or her field of expertise, but is also reputable. Oxford has taken appropriate steps to make sure our providers:
  - — Meet state licensure requirements.
  - — Meet clinical experience requirements and commit to continuing education in their discipline.
  - — Have specialty certification, where applicable.
  - — Meet malpractice requirements.
  - — Be credentialed every two years. Credentialing criteria have been established by expert providers through an Alternative Medicine Advisory Board.
- **Choice of Nearly 35,000 physicians**[1] - Nearly all are board-certified or board-eligible.
- **Fee-for-service** - Oxford pays doctors a fee for every covered service they provide, regardless of how many times a Member goes to the doctor's office.
- **96 percent of area pharmacies** - Members can fill their prescriptions at 96 percent of area pharmacies, including all major pharmacy chains.
- **Access to most of the area's finest hospitals** - Including New York Presbyterian, North Shore/LIJ, Yale/New Haven, and Robert Wood Johnson University Hospital.
- **OB/GYN without a referral** - Women can choose an OB/GYN, whom they can see in addition to their PCP, without a referral.

MAKING WELLNESS A PART OF YOUR LIFE

- **Accessing alternative care** - Members can access Oxford's alternative medicine network in one of two ways:
  - — **Contracted rate** - The contracted rate program allows all Oxford Members to visit any of Oxford's alternative medicine providers, without a PCP referral, at a specially negotiated rate. You simply select a participating provider, schedule an appointment, and pay the Oxford-negotiated rate directly to the provider at the time of your visit.
  - — **Standard in-network benefits** - For medically necessary care, members whose plan includes standard benefits for chiropractic coverage can visit any alternative medicine provider in Oxford's network. To take advantage of this benefit, you will need a referral from your PCP and will be responsible for a co-payment to the provider at the time of the visit.

- **Prescription drug coverage** - Prescription drug coverage is provided to employees whose employer does not offer a separate prescription drug plan. Prescription drug coverage is also provided to retirees. A $5 generic co-payment and a $10 brand name co-payment apply at a retail pharmacy for up to a 90-day supply. Mail order is also available, with a $5 generic co-payment and a $10 brand name co-payment for up to a 90-day supply.
- **No co-payments for in-network care** - Annual physicals, annual gynecological visits, routine pediatric care and immunizations.
- **Active Partner® program** - Personal reminders that encourage Members to receive important preventive care, including mammograms and flu shots.
- **Healthy Mother, Healthy Baby®** - Oxford's maternity program, designed to help maintain the health and well-being of pregnant mothers and newborns.
- **Healthy Bonus℠ program** - Discounts on optical services and fitness clubs.
- **Disease Management programs** - Proactive efforts to help Members manage chronic conditions, such as asthma or diabetes, through educational materials.

INFORMATION WHEN, WHERE, AND HOW YOU WANT IT

- **Oxford On-Call®** - A 24-hour healthcare guidance phone line staffed by Oxford Registered Nurses who can guide Members to an appropriate source of care.
- **www.oxfordhealth.com** - Self-service available via our web site: Members can search for providers, request materials, and order ID cards.
- **New service model** - Created to meet the needs of each of our customers: Member Service Associates focus on Member issues; and Provider Service Associates address physician needs.

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[1]As of 3/31/00, these data represent all participating providers except ancillary providers in Oxford's entire service area. Dental and alternative medicine providers are counted as specialists.

OXFORD HEALTH PLANS

To learn more, call: 1-800-760-4566

Oxford on the Internet: *www.oxfordhealth.com*

Introducing the best treatment of all...
Respect.

phs health plans℠
You Matter.™

www.phshealthplans.com

At PHS Health Plans, we believe the best thing for your good health is something called respect. We believe a member is a person, not a number or a file folder. We believe that courtesy and responsiveness count. And we believe that you should always have a significant say in your care. In other words, at PHS Health Plans, ***you matter!***

Here's how we show that ***you matter***:

No referrals needed: Who knows best when you need specialty care? We think you (and your doctor) do. That's why we give you open access to participating specialists. Open access means that you're able to see a participating specialist without a referral for just a $5 co-payment. PHS Health Plans is the only HMO plan in the State Health Benefits Program that does NOT require you to get a referral form from your Primary Care Physician to see a specialist.

Access to alternative medical treatments: More than 30 million Americans receive some form of alternative medical care every year. With our PHS AlternaCare℠ program, you'll have benefits for chiropractic care and acupuncture, and discounts on massage therapy and, through a special arrangement with **MotherNature.com™**, special discounts on vitamins, herbs, nutritional supplements and other natural products.

Convenient, toll-free customer service: We are available to answer your health benefit questions Monday through Friday, 8 a.m. to 6 p.m. Or you can e-mail your questions to us at: *member@PHSHealthPlans.com* Our service representatives can help you to select a participating physician or provider, answer your claim questions, and much more.

Choice of participating physicians/providers: If a large choice of physicians and providers is important to you, consider PHS Health Plans. At more than 59,000 provider locations, we have the largest physician/provider network in the tri-state (New Jersey/New York/Connecticut) area, including more than 20,000 provider office locations in New Jersey alone. There is a $5 co-payment for office visits with participating physicians and providers.

Preventive care to help you stay healthy: We provide coverage for adult/child well exams, childhood immu-

nizations, regular eye exams and cancer screenings. Plus, our female members are covered for regular gynecological visits.

Prescription Drug Coverage: A 30-day supply is available at participating pharmacies for a $5 generic co-payment and a $10 brand name co-payment. A 90-day supply is available through mail order for a $5 co-payment (generic or brand name). **Note:** Prescription drug coverage does not apply to those individuals who have coverage through another program offered by their employer.

Discounted contact lenses: Through TruVision™, you'll receive up to a 50 percent savings for doctor-prescribed contact lenses and supplies. And they are delivered to your home at no extra shipping or handling costs.

Discounts at health and fitness centers: You'll save money at fitness centers across the state through this program administered by WellQuest, Inc.

Talk to a nurse 24 hours a day: The convenient, free Personal Health Advisor® line helps you get answers to your health and medical questions when your doctor isn't available. The Personal Health Advisor® line is a toll-free call away, 24 hours a day, seven days a week.

Choice. Open Access. Preventive Care. Consider PHS Health Plans. We've got what you want!

At PHS Health Plans, ***you matter.*** That's why one million members count on us for quality health coverage for themselves and their families.

To learn more, or to see if your doctor is part of our extensive network, check out our web site at **www.phshealthplans.com**. You can even get a map and directions to the doctor's office.

PHS Health Plans
3501 State Highway 66
Neptune, New Jersey 07754
1-800-441-5741

PHS Health Plans is Physicians Health Services of New Jersey, Inc.

The Traditional Plan is an indemnity plan administered by Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). Under the plan, you have freedom of choice to seek medical treatment from any properly licensed provider, as defined by the plan, anywhere in the world. However, the plan only provides reimbursement of expenses for the diagnosis and treatment of illness and injury. The plan does not cover preventive treatment (with the exception of mammographies) such as immunizations, physical examinations, or well-care physician visits. The Traditional Plan has three components: basic benefits (hospitalization), extended basic benefits (medical-surgical/professional) and major medical benefits.

Basic Benefits

Basic benefits include inpatient covered services at an approved acute care hospital, skilled nursing facility, or detoxification facility; and outpatient covered services billed by an approved facility or home health care agency, birthing center, and same-day surgical center.

Extended Basic Benefits

Extended basic benefits, also known as medical-surgical or professional benefits are paid according to a fee schedule and cover certain charges billed by an eligible provider for services such as surgery, anesthesia, X-rays, laboratory tests, and inpatient medical care.

Major Medical Benefits

Major medical benefits provide coverage for eligible services such as physician charges, medical services, and other supplies not completely paid under the basic and extended basic portions of the Traditional Plan. Under major medical, there is annual deductible of $100 per employee and $200 ($100 per employee and $100 for one other covered family member) per family. Once the deductible has been met, the plan will pay 80 percent of either the remaining eligible charges or 80 percent of the reasonable and customary fee. After an individual has $2,000 in eligible major medical charges during a calendar year, the plan will pay 100 percent of eligible charges for the remainder of the calendar year. You are responsible for a 20 percent coinsurance (or $400 out-of-pocket per individual), plus any ineligible costs or charges that are denied as being above the reasonable and customary fee for a service within the area where it was provided. The lifetime benefit maximum, under the major medical portion of the Traditional Plan only, is $1,000,000 per individual. However, there is a limited automatic restoration feature whereby, at the start of each calendar year, any previously used amount of the lifetime maximum will be restored up to the lesser of $2,000 or the amount needed to completely restore the maximum.

Participating Traditional Plan Providers

Under the Traditional Plan, over 24,000 providers in NJ, NY, and PA participating with Horizon BCBSNJ, have agreed to accept the Horizon BCBSNJ allowance, and are precluded from billing above that amount. In addition, these providers have agreed to accept no payment at the time of

service and to submit claims on your behalf to Horizon BCBSNJ. You are only responsible for your annual deductible and 20 percent coinsurance based upon the discounted fee for eligible services, thereby reducing your out-of-pocket cost. There are similar arrangements with providers throughout the country with other Blue Cross and Blue Shield plans.

Prescription Drug Coverage

Active Local Employees -

Without a separate Prescription Program

If you are an active employee and your employer does not offer a prescription drug plan, the Traditional Plan provides a discounted prescription drug reimbursement program through major medical benefits. When you present your discount card to the pharmacist you are charged a reduced fee for your medication and your claim is electronically submitted to the carrier for payment. After deductibles are met the Traditional Plan will reimburse 80 percent of the prescription cost.

Prescription Drug Coverage - Retirees

Retail Pharmacy - up to 90-day supply co-payment amounts

Supply	Generic	Preferred Brand	All Other Brands
01-30 days	$5	$10	$20
31-60 days	$10	$20	$40
61-90 days	$15	$30	$60

Mail Order - 90-day supply co-payment amounts

Generic	$5 co-payment
Preferred Brand	$15 co-payment
All Other Brands	$25 co-payment

There is a $300 annual maximum in prescription drug co-payments per person. Once a person has paid $300 in co-payments in a calendar year, that person is no longer required to pay any drug co-payments for the remainder of that year. Prescription drug co-payments are not eligible for reimbursement and do not apply to the Traditional Plan deductible or co-insurance.

Traditional Plan Specialty Programs/ Features

SmartEyes^{SM} - a discount program for eyeglasses and accessories through more than 6,500 Cole Vision/Pearle Vision Centers nationwide. Cole Vision outlets can be found in Sears Optical Centers, JC Penney Optical Centers, and Montgomery Ward Vision Centers. Call 1-800-424-1155 for a location near you.

Centers of Excellence - a network of regional hospitals for bone marrow, heart, lung, liver and kidney transplants, should they be necessary.

For Additional Information - call Traditional Plan Customer Service at 1-800-414-SHBP (7427) during our service hours of Monday through Friday, 8:00 a.m. to 6:00 p.m. You may also access our interactive Web-Site at **www.horizon-bcbsnj.com** or write to us at:

Horizon Blue Cross Blue Shield of New Jersey
Traditional Plan
P.O. Box 1609
Newark, New Jersey 07101-1609

University Health Plans, Inc. (UHP) is a wholly-owned subsidiary of the prestigious University of Medicine and Dentistry of New Jersey (UMDNJ), and the only Managed-Care Organization in New Jersey owned by a health care institution. The health care delivery network comprises approximately 7,500 physicians, nearly 10,000 office locations and 83 hospitals, including member hospitals of the University Health System of New Jersey, a statewide network of teaching facilities.

When you choose **University Health Plans** you will receive care from some of the premier physicians in the nation, and you will see them in the comfort and convenience of their own private offices. Virtually all costs are covered (a five dollar co-payment is required for office visits and zero dollars for overnight hospital admission) when care is obtained from participating providers, and you can say good bye to hassles with claim forms and waiting to meet deductibles.

University Health Plans Offers You a Broad Range of Services such as:

- Physical exams
- Well baby care
- Specialty care
- Lab tests and x-rays
- Prescription drugs
- Immunizations
- Hospitalization
- 24 hour emergency and out of area coverage
- Wellness and health education programs
- Toll free member services number (1-800-JOIN-UHP)

Conveniently Located Physicians

One of the advantages of joining UHP is choosing your own Primary Care Physician. UHP participating Primary Care Physicians and Specialist are located throughout the state's 21 counties in approximately 10,000 office locations.

UHP Participating Hospitals are Among the Finest in the State

If you ever have to be hospitalized, you'll be admitted to one of UHP's affiliated hospitals. UHP has contracted with many of the premier hospitals in the state including: Hackensack University Medical Center, Robert Wood Johnson University Hospital. University of Medicine and Dentistry of New Jersey, St. Barnabas Medical Center, Morristown Memorial Hospital, Atlantic City Medical Center, and Jersey Shore Medical Center.

For a complete listing of affiliated hospitals, Specialists and Primary Care Physicians, please consult the UHP Provider Directory.

Protection for Emergencies

With UHP you have access to medical service 24 hours per day, 365 days per year. If an emergency occurs, simply call your Primary Care Physician. In the event of a life-threatening emergency, go to the nearest hospital emergency room. In an emergency, you are covered at any hospital. There is a $25 co-payment if a member is treated and released from the emergency room and the co-pay waived if the member is admitted to the hospital from the emergency room.

Prescription Drug Coverage

Prescription drug coverage is provided to retirees and employees whose employer does

not offer a separate drug plan. There is a $5 co-payment for generic drugs and $10 co-payment for brand name drugs (up to a 90-day supply at retail pharmacies). Members who are taking medications on an ongoing basis for chronic health conditions may take advantage of the mail order pharmacy service and receive up to a 90-day supply for one low co-payment. Prescriptions written by UHP affiliated physicians are accepted at most retail pharmacies throughout the country. The prescription drug program is administered by Merck-Medco, and its affiliate PAID Prescriptions, L.L.C.

Vision Plan

Members and eligible dependents are covered for a comprehensive refractive eye examination through a vision care plan administered by Davis Vision, a leading national administrator of vision programs. There is a co-payment of $5 per visit and members may self-refer themselves to a Davis Vision provider without a referral from their PCP.

Obstetrician and Gynecology Services

Female members may visit in-network Obstetricians/Gynecologists twice a year for well visit examinations without a referral from their PCP. There is a $5 co-payment per visit.

Health Education and Wellness

By now everyone agrees that a healthy lifestyle will help you feel better and live longer. UHP makes it easy for you. We have developed specific programs designed to keep members healthy. The stay healthy programs include, prenatal care, asthma and allergy care, well baby care, help with how to quit smoking, stop high blood pressure, control your cholesterol, signs and symptoms of diabetes. Members also receive by mail a quarterly newsletter called SmartMoves which addresses the advantages of health lifestyles and health promotion.

UHP Member Services

The UHP Member Services Department is available to assist members who have questions or concerns regarding their health care coverage. Member Services Representatives can be reached toll-free at 1-800-JOIN-UHP (1-800-564-6847) Monday through Friday from 9:00 a.m. to 5:00 p.m. We have representatives who speak many languages. UHP also contracts with a translation service so that members may communicate in their primary language if necessary.

FOR ADDITIONAL INFORMATION

Member services representatives are available to provide you with additional information or to answer your questions. You may call them Monday through Friday between the hours of 9 a.m. to 5 p.m. at 1-800-JOIN-UHP.

You may also contact **UHP** at: **University Health Plans, Inc**
550 Broad St.
Newark, N.J. 07102
(973) 623-8700

Our Web site address is: **www.uhpnet.com**

The following comparison charts provide an easy way to compare the various SHBP health plans by summarizing what benefits each plan provides for a specified service. Because the charts contain a lot of information, using the following helpful hints can make reading these charts easier.

If you are looking for how a specific service is covered - locate the service that you are inquiring about along the left-hand side of the chart. Follow horizontally across the chart to

COVERED EXPENSES

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN (800) 414-7427	#001 - NJ PLUS		#010 HORIZON HMO (800) 355-2583
			In-Network (800) 414-7427	Out-of-Network (800) 414-7427	
EXPENSES COVERED	HOSPITAL INPATIENT	100% for up to 365 days; day 366+ at 80% after deductible	100%	70% after $200 per hospital stay deductible	100%
	SKILLED NURSING FACILITY	100% up to 30 days per confinement	100% up to 120 days per calendar year	70% up to 60 days per calendar year	100% up to 120 days per calendar year
	HOSPITAL PRE-ADMISSION TESTING	100%	100%	70% after deductible	100%
	PHYSICIAN (SURGERY)	Basic benefit at 100%; balance at 80% after deductible	100%	70% after deductible	100%
	PHYSICIAN (OFFICE VISITS)	80% after deductible	100% after $5 per visit co-pay	70% after deductible	100% after $5 per visit co-pay
	CHIROPRACTIC	80% after deductible	100% after $5 per visit co-pay; no PCP referral required	70% after deductible	100% up to 20 visits per year, $5 co-pay; PCP referral required
	EMERGENCY ROOM - ACCIDENT/ NON-ACCIDENT	100% for accidental in-jury; 80% for non-accidental injury after deductible	100% after $25 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $25 co-pay if reported within 48 hours; otherwise subject to deductible and coinsurance	100% after $25 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.

compare how that particular service is covered by the various health plans. Determine which plan provides the best coverage for the services that you or your family may need.

If you are looking for information about a specific plan offered by the SHBP - locate the plan name along the top row. The specific services offered by that plan are listed in the column under the plan name.

COVERED EXPENSES

#019 - AETNA-US HEALTHCARE (800) 309-2386 Retiree on Medicare Call (800) 345-4432	**#020 CIGNA HEALTHCARE (800) 832-3211**	**#028 OXFORD (800) 444-6222**	**#033 AMERIHEALTH (800) 454-7651**	**#034 - PHYSICIANS HEALTH SERVICES (800) 535-3647**	**#036 - UNIVERSITY HEALTH PLANS (800) 564-6847**
100%	100%	100%	100%	100%	100%
100%; no maximum number of days	100% up to 120 days per calendar year	100% up to 120 days per calendar year	100% up to 180 days per calendar year	100% up to 120 days per confinement	100%; no maximum number of days
100%	100%	100%	100%	100%	100%
100%	100%	100%	100%	100%	100%
100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay
100% up to 20 visits per year, $5 co-pay; PCP referral required	100% up to 20 visits per year, $5 co-pay; PCP referral required	100% after $5 per visit co-pay PCP; referral required	100% for up to 60 days per injury medically necessary (if significant improvement occurs); referral required	100% after $5 per visit co-pay (up to 20 visits per calendar year); referral required	100% after $5 per visit co-pay; referral required
100% after $35 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $35 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $25 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $35 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $5 co-pay (if referred by PCP); or $25 co-pay (self-referred). Notice to PCP required within 48 hours, co-pay waived if admitted.	100% after $35 co-pay. Notice to PCP required within 48 hours, co-pay waived if admitted.

COVERED EXPENSES, *Continued*

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN (800) 414-7427	#001 - NJ PLUS		#010 HORIZON HMO (800) 355-2583
			In-Network (800) 414-7427	Out-of-Network (800) 414-7427	
EXPENSES COVERED	DURABLE MEDICAL EQUIPMENT	80% after deductible	90% reimbursement	70% after deductible	Special $100 co-pay; then 100% for rest of year
	RADIATION/ CHEMOTHERAPY OUTPATIENT	80% after deductible	100%	70% after deductible	100% after $5 co-pay per office visit
	HOSPICE	100%	100%	70% after deductible	100%
	IMMUNIZATIONS	Not covered	100% after $5 co-pay per visit (except for travel)	70% for children under 12 months, after deductible	100% after $5 co-pay per visit (except for travel)
	MATERNITY	Basic benefits at 100%; balance at 80% after deductible	100%; $5 co-pay for first office visit only	70% after deductible	$5 co-pay for first pre-natal office visit then 100% covered
	PHYSICAL EXAMS	Not covered	100% after $5 per visit co-pay	Not covered	100% after $5 per visit co-pay
	WELL BABY	Not covered	100% after $5 per visit co-pay	Not covered	100% after $5 per visit co-pay
	ALCOHOL ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab - 28 days at 100% per occurrence
	DRUG ABUSE (INPATIENT)	Same as any other illness	Same as any other illness	Same as any other illness	100% detox; rehab-28 days at 100% per occurrence
	ALCOHOL ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year
	DRUG ABUSE (OUTPATIENT)	Same as any other illness	100%, no visit limit	70% after deductible	100% up to 60 visits per calendar year

COVERED EXPENSES, *Continued*

#019 - AETNA-US HEALTHCARE (800) 309-2386 Retiree on Medicare Call (800) 345-4432	#020 CIGNA HEALTHCARE (800) 832-3211	#028 OXFORD (800) 444-6222	#033 AMERIHEALTH (800) 454-7651	#034 - PHYSICIANS HEALTH SERVICES (800) 535-3647	#036 - UNIVERSITY HEALTH PLANS (800) 564-6847
Special $100 co-pay; then 100% for rest of year	Special $100 co-pay; then 100% for rest of year	Special $100 co-pay; then 100% for rest of year	Special $100 co-pay; then 100% for rest of year	Special $100 co-pay; then 100% for rest of year	Special $100 co-pay; then 100% for rest of year
100% after $5 co-pay per office visit	100% after $5 co-pay per office visit	100% after $5 co-pay per office visit	100% after $5 co-pay per office visit	100% after $5 co-pay per office visit	100% after $5 co-pay per office visit
100%	100%	100%	100%	100%	100%
100% after $5 co-pay per visit (except for travel)	100% after $5 co-pay per visit (except for travel)	100% after $5 co-pay per visit (except for travel)	100% after $5 co-pay per visit (except for travel)	100% after $5 co-pay per visit (except for travel)	100% after $5 co-pay per visit (except for travel)
$5 co-pay for first prenatal office visit then 100% covered	$5 co-pay for first prenatal office visit then 100% covered	$5 co-pay for first prenatal office visit then 100% covered	$5 co-pay for first prenatal office visit then 100% covered	$5 co-pay for first prenatal office visit then 100% covered	$5 co-pay for first prenatal office visit then 100% covered
100% after $5 per visit co-pay	100% after $5 co-pay per visit (1 visit per calendar year)	100%	100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay
100% after $5 per visit co-pay	100% after $5 per visit co-pay	100%	100% after $5 per visit co-pay	100% after $5 per visit co-pay	100% after $5 per visit co-pay
100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox and rehab per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence
100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 30 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence	100% detox; rehab - 28 days at 100% per occurrence
100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year
100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year	100% up to 60 visits per calendar year

COVERED EXPENSES, *Continued*

	PLAN AND TELEPHONE NUMBER	#002 TRADITIONAL PLAN (800) 414-7427	#001 - NJ PLUS In-Network (800) 414-7427	#001 - NJ PLUS Out-of-Network (800) 414-7427	#010 HORIZON HMO (800) 355-2583
EXPENSES COVERED	**MENTAL[1] HEALTH (INPATIENT)**	100% for 20 days at member facility; balance at 80% after deductible up to annual/lifetime maximums	100% up to 25 days per calendar year; balance at 90% up to annual/lifetime maximums	50 days per calendar year at 50% after deductible up to annual/lifetime maximums	100% up to 30 days per calendar year
	MENTAL[1] HEALTH (OUTPATIENT)	80% after deductible up to $10,000 annual/ $20,000 lifetime maximum	90% up to $15,000 annual/$50,000 lifetime maximum	70% after deductible up to $15,000 annual/$50,000 lifetime maximum	100% for up to 30 visits per calendar year after $5 per visit co-pay
	PHYSICAL / SPEECH THERAPY	80% after deductible	100% after $5 per visit co-pay	70% after deductible	100% after $5 co-pay per visit up to 60 consecutive visits per condition
	DENTAL COVERAGE	None	None	None	None
	X-RAYS / LAB TESTS	80% after deductible; some charges paid at 100%	100% after $5 co-pay per visit	70% after deductible	100% after $5 co-pay per visit
	PRESCRIPTION DRUGS ***ACTIVE*** — Benefits for employees without an employer provided drug plan.	80% after deductible	90% coverage	70% after deductible	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $5 Generic co-pay - $5
	PRESCRIPTION DRUGS ***RETIREE***	Generic - co-pay $5 Preferred brand - $10 Other brands - $20 Mail Order: generic - $5 preferred brand - $15 other brands - $25 $300 Maximum co-pay per member per year.	Generic - co-pay $5 Preferred brand - $10 Other brands - $20 Mail Order: generic - $5 preferred brand - $15 other brands - $25 $300 Maximum co-pay per member per year.	Generic - co-pay $5 Preferred brand - $10 Other brands - $20 Mail Order: generic - $5 preferred brand - $15 other brands - $25 $300 Maximum co-pay per member per year.	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $5 Generic co-pay - $5
	ROUTINE VISION EXAM	None	100% after $5 co-pay; one exam per calendar year; no referral	None	100% after $5 co-pay; one exam per calendar year; no referral

[1]Biologically-based mental health conditions are treated like any other illness and not subject to annual or lifetime mental health dollar maximums or separate mental health visits.

COVERED EXPENSES, *Continued*

#019 - AETNA-US HEALTHCARE (800) 309-2386 Retiree on Medicare Call (800) 345-4432	#020 CIGNA HEALTHCARE (800) 832-3211	#028 OXFORD (800) 444-6222	#033 AMERIHEALTH (800) 454-7651	#034 - PHYSICIANS HEALTH SERVICES (800) 535-3647	#036 - UNIVERSITY HEALTH PLANS (800) 564-6847
100% up to 35 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year	100% up to 30 days per calendar year
100% after $10 co-pay per visit (limited to 30 visits per calendar year)	100% after $5 co-pay per visit (30 visits/year); group co-pay $5 per visit	100% after $10 co-pay per visit for up to 30 visits per calendar year	100% after $10 co-pay per visit for up to 30 visits per calendar year	100% after $5 co-pay per visit for up to 30 visits per calendar year	100% after $5 co-pay per visit for up to 30 visits per calendar year
100% after $5 co-pay per visit (up to 60 consecutive days per incident)	100% after $5 co-pay per office visit; 60 consecutive days per condition	100% after $5 co-pay per visit (60 visits per occurrence	100% for up to 60 consecutive days per condition	100% after $5 co-pay per office visit for up to 60 days after first treatment	100% after $5 per visit co-pay; maximum 60 visits per calendar year
None	None	Exams and cleaning for members under age 12	Exams, cleaning, and fluoride treatments for members under age 12	None	None
100% after $5 co-pay per visit	100%	100%	100%	100%	100%
Brand co-pay - $10 Generic co-pay - $10 Mail Order: Brand co-pay - $10 Generic co-pay - $10	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $10 Generic co-pay - $10	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $10 Generic co-pay - $5	Brand co-pay - $10 Generic co-pay - $6 Mail Order: Brand co-pay - $10 Generic co-pay - $6	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $5 Generic co-pay - $5	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - NA Generic co-pay - NA
Brand co-pay - $10 Generic co-pay - $10 Mail Order: Brand co-pay - $10 Generic co-pay - $10	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $10 Generic co-pay - $10	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $10 Generic co-pay - $5	Brand co-pay - $10 Generic co-pay - $6 Mail Order: Brand co-pay - $10 Generic co-pay - $6	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - $5 Generic co-pay - $5	Brand co-pay - $10 Generic co-pay - $5 Mail Order: Brand co-pay - NA Generic co-pay - NA
100% after $5 co-pay; exam every 2 years; no referral	100% after $5 co-pay; one exam per calendar year; referral needed	$50 reimbursed toward routine exam per 12 month period	100% after $5 co-pay; one exam every 24 month period; must use specified vendor	100% after $5 co-pay; one exam per calendar year; no referrals	100% after $5 co-pay; for annual exam; must use specified vendor

HMO PLAN STANDARDS

The SHBP has established minimum coverage requirements and operating standards for all participating HMOs that safeguard our members and make it easier to compare and choose between plans. The following is not a benefit summary but a listing of benefit coverage for which the SHBP has imposed a mandatory expectation or requirement.

Operating Standards Include:

— All physician referrals will be valid for a minimum of 90 days from the date of authorization.

— Certain treatments requiring numerous visits (e.g., chemotherapy) shall not require repeated referrals.

— All plans will have two-level grievance procedures; maximum fourteen-day final verdict.

— Member packets must include a Schedule of Benefits which will provide a list of covered services, benefit limitations and benefit exclusions, and appropriate definitions.

— The HMO will notify the State and members prior to any proposed changes in the provider network, including facilities, that alter member access to providers or services.

— There shall be no pre-existing condition restrictions.

— Network within network referral restrictions will not be permitted.

— Right to change Primary Care Providers must be permitted on at least a monthly basis.

— Scope of services covered under the well-woman OB/GYN provisions must be clearly defined, including the explicit services which must be authorized by the member's PCP. It is required that two or more well-woman OB/GYN examinations be available during the Benefit Plan Year, and that a well-woman mammogram not require a PCP authorization.

— HMO members must be permitted to self-refer to network mental health and substance abuse practitioners.

— Extension of health benefits must be made at no cost to totally disabled members who do not elect COBRA coverage and to those whose coverage terminates at the end of the COBRA continuation period including cessation of premium payments. The extension is made available to those members who are totally disabled on the date their coverage terminates and need not require hospital confinement, and is only applicable to expenses incurred in the treatment of the disabling condition. The extension period will end on the earliest of:

- the date the total disability ends;
- one year from the date the person's coverage under the SHBP ends;

- the date the person has received the maximum benefits under the HMO's Plan for the disabling condition; or
- the person becomes covered under any replacement plan established by the employer.

Emergency

— The following definition for emergency care will be adhered to by all plans:

Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b) serious impairment to bodily function; or

c) serious dysfunction of any bodily organ or part.

— There will be a $35 maximum co-payment for emergency room services; waived if admitted.

— With respect to emergency services furnished in a hospital emergency department, a health plan shall not require prior authorization for the provision of such services if the member arrived at the emergency medical department with symptoms that reasonably suggested an emergency condition based on the judgment of a prudent layperson, regardless of whether the hospital was affiliated with the Health Maintenance Organization. All procedures performed during the evaluation (triage) and treatment of an emergency medical condition shall be covered by the Health Maintenance Organization.

Minimum Coverage Requirements

Benefit standards include:

— Routine office visit co-payments will be $5.

— All plans will cover chiropractor visits up to a maximum of 20.

— $100 will be the maximum annual co-payment for medical appliances and durable medical equipment.

— Hair prosthesis furnished in connection with hair loss resulting from the treatment of disease by radiation or chemicals will be covered.

— Routine inoculations for adults (not related to travel or occupation) will be covered.

— The cost of care to organ transplant donors will be covered. (Coordination of benefits will apply.)

— Admissions at skilled nursing homes will be covered up to 120 days.

— Hospice services will be covered in full.

— Home health care will be covered up to a minimum of 120 visits.

— Outpatient therapy will be covered up to 60 visits per condition.

— Repair and replacement of prosthesis will be covered.

— Surgical leggings will be covered if medically necessary.

— There will be no reimbursement for vision hardware.

Mental Health and Alcohol/Substance Abuse

— There will be no co-payment charged for outpatient drug and alcohol rehabilitation treatment.

— All plans will use standard treatment criteria established by the American Society of Addictive Medicine (ASAM).

— Following a detoxification patients are entitled to 28 days of inpatient rehabilitation per occurrence.

— Biologically-based mental heath conditions are treated like any other illness.

STATE HEALTH BENEFITS PROGRAM INFORMATION

ACTIVE EMPLOYEE ELIGIBILITY

Eligibility for coverage is determined by the State Health Benefits Program (SHBP). Enrollments, terminations, changes to contracts, etc. must be presented through your employer to the SHBP. If you have any questions concerning eligibility provisions, you should call the Division of Pensions and Benefits' Office of Client Services at (609) 292-7524.

To be eligible for State employee coverage, you must work full-time or be an appointed or an elected officer of the State of New Jersey. For State employees, full-time normally requires 35 hours per week.

To be eligible for local employer coverage, you must be a full-time employee or an appointed or elected officer receiving a salary. Each employer defines the minimum hours required for full-time by a resolution filed with the SHBP, but it can be no less than an average of 20 hours per week. Employment must also be for 12 months per year except for employees whose usual work schedule is 10 months per year.

Eligible Dependents

Your eligible dependents are your spouse and/or your unmarried children under age 23 who live with you in a regular parent-child relationship. This includes children who are away at school as well as divorced children living at home and dependent upon you for support. If you are divorced, your children who do not live with you are eligible if you are legally required to support those children. Stepchildren, foster children, legally adopted children, and children in a guardian-ward relationship are also eligible provided they live with you and are substantially dependent upon you for support and maintenance. *Affidavits of Dependency* and legal documentation are required with enrollment forms for these cases. Coverage for an enrolled child will end when the child marries, moves out of the household, or turns age 23. Coverage for children age 23 ends on December 31 of the year in which they turn age 23 (see the COBRA section on page 48 for continuation of coverage provisions).

If a child is not capable of self-support when (s)he reaches age 23 due to mental illness, mental retardation, or a physical disability, coverage under the SHBP may be continued. To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, 50 West State Street, P. O. Box 299, Trenton, New Jersey 08625 for a *Continuance for Dependent with Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent with Disabilities* form. Coverage for children with disabilities may continue only while (1) you are covered through the SHBP, and (2) the child continues to be disabled, and (3) the child is unmarried, and (4) the child remains dependent on you for support and maintenance. You will be contacted periodically to verify that the child remains eligible for continued coverage.

Enrollment

You are not covered until you enroll in the SHBP. You must fill out a *NJ State Health Benefits*

Program Application and provide all the information requested. If you do not enroll all eligible members of your family within 60 days of the time you or they first become eligible for coverage, you must wait until the next Open Enrollment period to do so (see exceptions below). Open Enrollment periods generally occur once a year. Information concerning the duration of the Open Enrollment period and effective dates of coverage are announced by the Division of Pensions and Benefits.

Change of Coverage

To change your coverage you should contact your benefits administrator or human resource representative and complete a *NJ State Health Benefits Program Application*. You are eligible to change your coverage under the following circumstances.

- — You marry and want to enroll your spouse and newly eligible dependent children. You must file a new *NJ State Health Benefits Program Application* within 60 days of the marriage.
- — You need to enroll a new child. You must file a new *NJ State Health Benefits Program Application* within 60 days after birth or adoption and submit legal documentation.
- — You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives with you, or turns 23).
- — You move out of a plan's service area. You can change plans immediately; however, if you do not change within 30 days of the move, you must wait until the next Annual Open Enrollment period.
- — You are going on a leave of absence and cannot afford to pay for coverage. You can reduce your coverage, for example, from family to parent and child when you go on leave and increase it back to family upon your return to work.
- — Your spouse's or eligible dependent's employment status changes resulting in a loss of health coverage. You have 60 days from the date of the event to make adjustments to your coverage that are necessary to compensate for the loss of this coverage. A copy of your spouse's and or dependent's Certificate of Continued Coverage must be submitted with the *NJ State Health Benefits Program Application*.
- — Your child, under the age of 23, has divorced and moves back into your household, and is dependent upon you for support and maintenance. You must file a *NJ State Health Benefits Program Application* within 60 days after the child has returned home, with a copy of the child's divorce decree, if you wish to enroll this child under your coverage.

Effective Dates of Coverage

There is a waiting period of two months following your date of hire before your SHBP health benefits coverage begins, provided you submit a completed *NJ State Health Benefits Program Application*. Your enrolled eligible dependent's coverage is effective the same date as yours provided you have paid any required contribution.

Coverage for State biweekly employees begins on the first day of your fifth payroll period. The

exact date of your coverage will be determined by the State's centralized payroll date schedule. Contact your benefits administrator or human resource representative if you need to know the exact date of coverage.

If you are a local government or local education employee or a State monthly employee, your coverage begins on the first day following two months of employment. For example, if you start work on September 15, your coverage will be effective November 15. The following *exceptions* apply to this effective date of coverage.

- If you have at least two months of service on the date your employer joins the SHBP, your coverage starts on the date your employer enters the program.
- If you have an annual contract, are paid on a 10-month basis, and begin work at the beginning of the contract year, your coverage will begin on September 1.
- If you were enrolled in the SHBP with your previous employer and your coverage is still in effect on the day you begin work with your current employer (COBRA coverage excluded), your coverage begins immediately so you have no break in coverage. (See Transfer of Employment, below.)

Coverage changes involving the addition of dependents are effective retroactive to the date of the event (marriage, birth, adoption, etc.) providing the application is filed within 60 days of the event. Deletion of dependents is effective on a timely or prospective basis, depending upon receipt of the application by the Health Benefits Bureau. Dependent children are automatically terminated as of the end of the year they attain age 23 and do not require the completion of an application to decrease coverage.

Transfer of Employment

If you transfer from one SHBP-eligible employer to another, including transfer within State employment, coverage may be continued without any waiting period provided that you:

- are still covered by the SHBP (COBRA coverage excluded) when you begin in your new position; or
- transfer from one participating employer to another; **and**
- file a new *NJ State Health Benefits Program Application* listing the former employer in the appropriate section of the application.

Leaves of Absence

Leaves of absence encompass all approved leaves with or without pay. These include:

- Approved leave of absence for illness.
- Approved leave of absence other than illness.
- Family Leave Act (federal and state).
- Furlough.
- Workers' Compensation.
- Suspension (COBRA continuation only).

When you take an approved leave of absence, you may reduce your coverage (for financial reasons) and increase it again when you return from leave. When you return to work, your benefits and those of your eligible family members are reinstated upon completion of a *NJ State*

Health Benefits Program Application. Contact your benefits administrator or human resources representative for more information concerning coverage while on leave of absence. When the leave of absence is due to suspension, you are not eligible for benefits, with the possible exception of COBRA.

Family and Medical Leave Act

State and local employees participating in the SHBP are entitled to have their coverage continued at the expense of their employer while they are on family leave. To qualify for the federal Family and Medical Leave Act of 1993 (FMLA), you must have a personal illness, a newborn child, or need to care for an ill family member, and be employed for 12 months. The FMLA defines the family member as a spouse, parent, or child. The FMLA provides up to 12 weeks in a 12-month period.

To qualify for the New Jersey Family Leave Act (NJFLA), you must have a need to care for an ill family member or a newborn child. There is no provision for an employee's own personal illness. The NJFLA provides up to 12 weeks in a 24-month period.

If an employee takes a leave for the care of a family member, both the FMLA and the NJFLA will run concurrently. If an employee takes a leave for maternity, they are on the FMLA. After their doctor releases them from their maternity leave, they can take the NJFLA for the care of the newborn child. This then provides the parent with up to 24 weeks of employer paid benefits.

Furlough

If you take an approved furlough, your SHBP coverage will continue at the employer's expense. You must remit to your employer, in advance, that portion of the premiums you normally pay, if any.

For State employees, voluntary furlough extensions beyond the normal 30 days allowed will be treated as an exceptional case. You will have to pay for the full cost of coverage for your extended furlough days in 10-day increments or drop your coverage for the entire benefit period(s) in which you take a furlough day.

End of Coverage

Coverage for you and your dependents will end if:

- — you voluntarily terminate coverage;
- — your employment terminates;
- — your hours are reduced so you no longer qualify for coverage;
- — you take a leave of absence and do not make required premium payments;
- — you enter the Armed Forces and are eligible for government-sponsored health services;
- — your employer ceases to participate in the SHBP; or
- — the SHBP is discontinued.

Coverage for your dependents will end if:

- — your coverage ceases for any of the reasons listed above;

— you die;
— your dependent is no longer eligible for coverage (divorce of a spouse; children marry, move out of the household, or turn age 23 unless the dependent child qualifies for continuance of coverage due to disability (see page 39);
— your payment for coverage is not made when due; or
— your enrolled dependent enters the Armed Forces.

Return from Leave of Absence

If your coverage has terminated while on an approved leave of absence, when you return from the leave, your benefits and those of your eligible family members are reinstated after you complete a *NJ State Health Benefits Program Application*. **You must complete this application within 60 days after you return to work.** Coverage becomes effective on the date you return to work if you are a State monthly or local employee or on the first day of the pay period in which you return to work if you are a State biweekly employee. You may enroll in any plan at any level of coverage for which you are eligible when you return from an approved leave of absence. This reinstatement provision applies to all approved leaves.

If you retained your coverage at a reduced level while on an approved leave of absence, you may return to your former level of coverage or any other eligible level of coverage upon your return to work.

If you retained your coverage at a reduced level while on a leave of absence and were not actively at work during an Open Enrollment period, you may make Open Enrollment types of changes to your coverage when you return to work. These changes will be effective immediately upon your return to work.

If you are absent for a full pay period (State biweekly employee) and your coverage was terminated, or you purchased COBRA coverage while on leave, you must file a new *NJ State Health Benefits Program Application* **within 60 days** of the first day of your return to work. In addition, filing your application as soon as possible upon your return to work will help to ensure a timely re-enrollment.

Workers' Compensation

If you have a Workers' Compensation award pending or have received an award of periodic benefits under Workers' Compensation or the Second Injury Fund, you and your dependents are entitled to have continued coverage at the same contribution level as when you were an active employee. You must remit to your employer, in advance, that portion or the premiums that you would normally pay, if any.

Medicare Parts A and B

It is not necessary for a Medicare-eligible employee or spouse to be covered by Medicare while they remain actively at work. It is required that they enroll in both Parts A and B prior to retirement so that coverage will be effective at the time of retirement.

RETIREE COVERAGE

The SHBP is notified when you file an application for retirement with the Division of Pensions and Benefits. If eligible, you will receive a letter inviting you to enroll in the SHBP's Retired Group coverage. Early filing is recommended to prevent any lapse of coverage or delay of eligibility.

Medicare Coverage

IMPORTANT: A Retired Group member and/or dependent spouse who is eligible for Medicare coverage by reason of age or disability must be enrolled in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to enroll or remain in SHBP Retired Group coverage.

You will be required to submit documentation of enrollment in Medicare Parts A and B when you become eligible for that coverage. Acceptable documentation includes a photocopy of your Medicare card showing both your Part A and B enrollment or a letter from Medicare indicating the effective dates of both your Parts A and B coverage. Send your evidence of enrollment to the Health Benefits Bureau, Division of Pensions and Benefits, 50 West State Street, PO Box 299, Trenton, New Jersey 08625. If you do not submit evidence of Medicare coverage under both Parts A and B, you and/or your dependents will be terminated from the SHBP. Upon submission of proof of full Medicare coverage, your coverage will be reinstated by the SHBP.

IMPORTANT: If a provider does not participate with Medicare, no benefits are payable under the SHBP for the provider's services.

A Member May be Eligible for Medicare for the Following Reasons:

— ***Medicare Eligibility by Reason of Age***

This applies to a member who is the employee or covered spouse and is at least 65 years of age.

A member is considered to be eligible for Medicare by reason of age from the first day of the month during which (s)he reaches age 65. However, if (s)he is born on the first day of a month, (s)he is considered to be eligible for Medicare from the first day of the month which is immediately prior to his/her 65th birthday.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reason of Disability***

This applies to a member who is under age 65.

A member is considered to be eligible for Medicare by reason of disability if they have been receiving Social Security Disability benefits for 24 months.

The health plan is the secondary plan.

— ***Medicare Eligibility by Reasons of End Stage Renal Disease***

A member usually becomes eligible for Medicare at age 65 or upon receiving Social Security Disability benefits for two years. A member who is not eligible for Medicare because of age or disability may qualify because of treatment for End Stage Renal Disease (ESRD). When a person is eligible for Medicare due to

ESRD, Medicare is the secondary payer when:

- The individual has group health coverage of their own or through a family member (including a spouse).
- The group health coverage is from either a current employer or a former employer. The employer may be of any size (not limited to employers with more than 20 employees).

The above rules, known as the Medicare Secondary Payer (MSP) rules are federal regulations that determine whether Medicare pays first or second to the group health plan. These rules have changed over time.

As of 2000, where the member becomes eligible for Medicare solely on the basis of ESRD, the MEDICARE eligibility can be segmented into three parts: (1) an initial three-month waiting period; (2) a "coordination of benefits" period; and (3) a period where Medicare is primary.

Three-month waiting period

Once a person has begun a regular course of renal dialysis for treatment of ESRD, there is a three-month waiting period before the individual becomes entitled to Medicare Parts A and B benefits. During the initial three-month period, the group health plan is primary.

Coordination of benefits period

During the "coordination of benefits" period, Medicare is secondary to the group health plan coverage. Claims are processed first under the health plan. Medicare considers the claims as a secondary carrier. For members who became eligible for Medicare due solely to ESRD after 1996, the coordination of benefits period is 30 months.

When Medicare is primary

After the coordination of benefits period ends, Medicare is considered the primary payer and the group health plan is secondary.

— ***Dual Medicare Eligibility***

When the member is eligible for Medicare because of age or disability and then becomes eligible for Medicare because of ESRD:

- If the health plan is primary because the member has active employment status, then the group health plan continues to be primary to 30 months from the date of dual Medicare entitlement.
- If the health plan is secondary because the member is not actively employed, then the health plan continues to be the secondary payer. There is no 30-month coordination period.

How to File a Claim If You Are Eligible for Medicare

When filing your claim, follow the procedure listed below that applies to you.

New Jersey Physicians or Providers:

— You should provide the physician or provider with your identification number.

This number is indicated on the *Medicare Request for Payment* (claim form) under "Other Health Insurance."

— The physician or provider will then submit the *Medicare Request for Payment* to the Medicare Part B carrier.

— After Medicare has taken action, you will receive an *Explanation of Benefits* form from Medicare.

— If the remarks section of the *Explanation of Benefits* contains the following statement, you need not take any action: "This information has been forwarded to (name of your SHBP plan) for their consideration in processing supplementary coverage benefits."

— If the above statement does not appear on the *Explanation of Benefits,* you should indicate your Social Security number and the name and address of the physician or provider in the remarks section of the *Explanation of Benefits* with a completed claim form and send it to the address on the claim form.

Out-Of-State Physicians or Providers:

— The *Medicare Request for Payment* form should be submitted to the Medicare Part B carrier in the area where services were performed. Call your local Social Security office for information.

— When you receive the *Explanation of Benefits,* indicate your identification number and the name and address of the physician or provider in the remarks section and send the *Explanation of Benefits* with a completed claim form to the address on the claim form.

Eligible Dependents of Retirees

Dependent eligibility rules for Retired Group coverage are the same as for Active Group coverage except for Medicare requirements as stated above.

Change of Coverage

To change your coverage you should contact the Office of Client Services at the Division of Pensions and Benefits and request a *SHBP Retired Status Application.* You are eligible to change and should change your coverage under the following circumstances.

— You marry and want to enroll your spouse.

— You need to enroll a new child.

— You have a change in family status involving the loss of eligibility of a family member (separation, divorce, death, child marries, no longer lives at home, or turns age 23).

— You wish to change your medical plan. A Retired Group member can switch medical plans once in any 12-month period or when rates change.

— You move out of the plan's service area. The 12-month change rule mentioned above is waived in cases like this.

— Your spouse's employment status changes resulting in a significant change in health coverage.

IMPORTANT: Retirees should immediately notify the Health Benefits Bureau of changes in family status. (1) Deleting coverage for dependents may affect premium rates and, although claims for ineligible dependents cannot legally be paid, *premiums cannot be reduced until appropriate notification is provided to the Health Benefits Bureau*. (2) Failure to submit a *SHBP Retired Status Application* to remove from your coverage a deceased or ineligible spouse for whom you receive a Medicare Part B reimbursement will result in the need for you to reimburse all incorrectly paid amounts.

SPECIAL RETIRED GROUP RULES

Limitations on Enrolling Dependents and Changing Coverage

Eligible dependents can be added to Retired Group coverage upon initial enrollment of the retiree and within 60 days of a change of family status (marriage, birth of child, etc.) that made the dependent eligible. The family member will be enrolled retroactive to the date of eligibility.

If the application to add a spouse or dependent is not received within 60 days of the status change, there will be a minimum 2 month waiting period from the date the enrollment application is received until the member is covered — beginning the first of the month following the expiration of the waiting period. You may remove family members from coverage at any time. Decreases in coverage will be processed on a timely basis. **It is your responsibility to notify the SHBP of any change in family status.** If family members are not properly enrolled, claims will not be paid.

Effective Dates

The effective date of any change in which a dependent is added to coverage because of **marriage, birth, or adoption** is the first of the month in which the event occurred if the *Retired Status Application* is filed within 60 days of the event (marriage, birth, adoption, etc.) with the SHBP. If the *Retired Status Application* is not received within 60 days of the event by the SHBP, the effective date will be the first of the month following a full two-month waiting period from the date of receipt of the application.

You are responsible for notifying the Health Benefits Bureau of a coverage change due to **death or divorce**. The effective date is the first day of the month following the date of death or divorce. Any claims incurred or services provided after this date are ineligible for payment.

The effective date of **any other change or termination of coverage** is based on the billing cycle in which the change or termination is received. In most cases, if an application for a change is received before, for example, January 15, the effective date will be February 1. If the application is received after January 15, the effective date will be March 1. The effective date of any transaction may be delayed if the member fails to submit the appropriate application and supporting information on a timely basis.

End of Coverage

Your coverage under the Retired Group terminates if:

— you formally request termination in writing, or by completing a *SHBP Retired Status Application;*

— your retirement is canceled;
— your pension allowance is suspended;
— you do not pay your required premiums;
— your plan discontinues services in your area and you do not submit an application to the SHBP to change to another plan;
— you or your spouse do not provide proof of enrollment in Medicare Parts A and B when eligible for Medicare coverage;
— your former employer withdraws from the SHBP (this may not apply to certain retirees of education, police, and fire employers);
— your Medicare coverage ends;
— you die; or
— the SHBP is discontinued.

Once coverage is terminated you are not normally permitted to be reinstated.

Survivor Coverage

If you, the retired member, predecease your covered spouse and/or other covered eligible dependents, your surviving dependents may be eligible for continued coverage in the SHBP. Surviving dependents are generally notified of their rights to continued coverage at the time the Division of Pensions and Benefits is notified of the death of the retiree; however, they may contact the Division of Pensions and Benefits' Office of Client Services for enrollment forms or for more information. It is imperative that survivors notify the Division of Pensions and Benefits as soon as possible after your death because their dependent coverage ends on the first of the month after the date of your death.

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods (see Duration of Coverage, on page 49), and the member must pay the full cost of the coverage plus an administrative fee.

Leave taken under the federal and/or State Family Leave Act is no longer subtracted from your COBRA eligibility period.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll in any SHBP medical coverage and, if offered by your employer, State prescription drug coverage during the SHBP Open Enrollment period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the SHBP Open Enrollment period as an active

employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- — Termination of employment (except for gross misconduct).
- — Death of the member.
- — Reduction in work hours.
- — Leave of absence.
- — Divorce or legal separation (makes spouse ineligible for further coverage).
- — Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.
- — The employee elects Medicare as primary coverage. (Federal law requires active employees to terminate their employer's health coverage if they want Medicare as their primary coverage.)

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a two percent charge for administrative costs.

Duration of Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of **termination of employment, a reduction in hours, or a leave of absence**.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if (s)he becomes eligible because of your **death or divorce**, or (s)he becomes ineligible for continued group coverage because of **marriage, attaining age 23, or moving out of the household**, or because you **elected Medicare as your primary coverage.**

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- notify you and your dependents of the COBRA provisions when you and your dependents are first enrolled;
- notify you, your spouse, and your children of the right to purchase continued coverage when they become aware of a COBRA event that causes a loss of coverage;
- send the *COBRA Notification Letter* and a *COBRA Application* within 14 calendar days of receiving notice that a qualifying event has occurred; and
- maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- notify your employer (if you are retired, you must notify the Health Benefits Bureau of the Division of Pensions and Benefits) that a divorce, legal separation, or death has occurred or that your child has married, moved out of your household, or reached age 23 - notification must be given within 60 days of the date the event occurred;
- file a *COBRA Application* within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- pay the required monthly premiums in a timely manner; and
- pay premiums, when billed, retroactive to the date of group coverage termination.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- your eligibility period expires;
- you fail to pay your premiums in a timely manner;
- after the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- you voluntarily cancel your coverage;
- your employer drops out of the SHBP;
- you become eligible for Medicare after you elect COBRA coverage. (This affects health insurance only, not dental, prescription, or vision coverage.)

WOMEN'S HEALTH AND CANCER RIGHTS ACT

Effective October 21, 1998, the State Health Benefits Commission adopted as policy, the federal mandate "Women's Health and Cancer Rights Act of 1998." The mandate requires that plans, which cover mastectomies, must cover breast reconstruction; surgery to produce a symmetrical appearance; prostheses; and treatment of any physical complications.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires group health plans to implement several provisions contained within the law or notify its membership each plan year of any provisions from which they may file an exemption. Self-funded, non-federal government plans may elect certain exemptions from compliance with HIPAA provisions on a year-to-year basis.

Act Requirements

For the plan year that began January 1, 2000, all SHBP health plans will meet or exceed the federal requirements with the exception of mental health parity for the Traditional Plan and NJ PLUS. Parity requires that the dollar limitations on mental health benefits are not lower than those of medical or surgical benefits.

Mental Health Parity

The State Health Benefits Commission has filed an exemption from the mental health parity requirement with the federal Health Care Financing Administration for calendar year 2000. As a result, the maximum annual and lifetime dollar limits for mental health benefits under the Traditional Plan and NJ PLUS will not change, with the exception for *biologically-based* mental illness (see page 6). Maximum annual and lifetime dollar limits for mental health benefits are outlined in the comparison charts (beginning on page 30).

Certification of Coverage

HIPAA rules state that if a person was previously covered under another group health plan, that coverage period will be credited toward any pre-existing condition limitation period for the new plan. Credit under this plan includes any prior group plan that was in effect 90 days prior to the individual's effective date under the new plan. A *Certification of Coverage* (COC) form, which verifies your group health plan enrollment and termination dates, is available through your payroll or human resource office, should you terminate your coverage.

PURCHASE OF INDIVIDUAL INSURANCE COVERAGE

Employees, retirees, and their dependents may purchase individual, direct payment coverage from their State Health Benefits Program (SHBP) health plan carrier if their loss of group health coverage is due to any reason other than voluntary termination. Note: failure to pay required premiums is considered voluntary termination.

Before considering a converted policy, New Jersey residents who are not Medicare eligible, should first investigate coverage available under the provisions of the New Jersey Individual Health Coverage Program. Information about available policies can be obtained from the New Jersey Individual Health Coverage Board at the Department of Banking and Insurance. Carrier and rate information can be obtained by calling 1-800-838-0935 or at *www.njdobi.org*

If you are Medicare eligible you may qualify for a Medigap policy through the New Jersey Department of Health and Senior Services — State Health Insurance Program (SHIP). For more information, contact SHIP at 1-800-792-8820.

You will have 31 days from the end of your SHBP coverage to exercise your right to conversion.

EXTENSION OF BENEFITS

If you are disabled with a condition or illness at the time of your termination from the SHBP and you have no other group medical coverage, you may qualify for an extension of benefits for this condition or illness. If you feel that you may qualify for an extension of benefits please contact your claims administrator for assistance.

If the extension applies, it is only for expenses relating to the disabling condition or illness. An extension, under any SHBP plan, will be for the time a member remains disabled from any such condition or illness, but not beyond the end of the calendar year after the one in which the person ceases to be a covered person. During an extension there will be no automatic restoration of part or all of a lifetime benefit maximum.

CLAIM APPEAL PROCEDURES

You or your authorized representative may appeal and request that your health plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

If dissatisfied with a final health plan decision on a medical appeal, only the member or the member's legal representative may appeal, in writing, to the State Health Benefits Commission. If the member is deceased or incapacitated, the individual legally entrusted with his or her affairs may act on the member's behalf. Request for consideration must contain the reason for the disagreement along with copies of all relevant correspondence and should be directed to the following address:

Appeals Coordinator
State Health Benefits Commission
PO Box 299
Trenton, NJ 08625-0299

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the

Commission's decision may request, within 45 days in writing to the Commission, that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so the case will be forwarded to the Office of Administrative Law. An Administrative Law Judge (ALJ) will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If the recommendation is rejected, the administrative appeal process is ended. When the administrative process is ended, further appeals will be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. You will be responsible for any court filing fees or related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Failure to respond to the audit will result in the termination from coverage of eligible dependents. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated.